Slide 1: Evidential Preferences and Who We Trust: Health Education and Decision Making

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Slide 2: Informed Decision Making (1 of 2)

- Understands the nature and risks
- Understands the risks and benefits
- Understands alternatives
- Participates in decision making at a level he or she desires
- Makes a decision consistent with his or her preference and values

Slide 3: Informed Decision Making (2 of 2)

- Patients are now expected to be fully engaged in a complex health care system.
 - Combination of disease comprehension
 - Awareness of health behavior and treatment guidelines/options
 - o Ability to comprehend risk/benefit data
 - Insurance utilization issues
 - o Uncertainty, lack of knowledge may result in:
 - Failure to engage in health decision making
 - Deference to physicians or other health providers or simply to what the health system proscribes
 - Reliance on data consistent with experience and beliefs

Slide 4: Changes Affecting Clinical Dialogue (1 of 3)

- Eighty percent of Internet users or 59 percent of the U.S. adult population has searched for health information online.
- The clinical encounter is now influenced by a patient who may be armed with information.
- This increases the relevance of knowledge about how people respond to and use health information.

Slide 5: Changes Affecting Clinical Dialogue (2 of 3)

- Physicians were reportedly trusted sources of information.
 - Despite discussions of mistrust; physicians are a trusted source of health information.

Slide 6: Changes Affecting Clinical Dialogue (3 of 3)

- Media are important sources of information.
 - Ethnic minority media are trusted and valued by members of their communities.
 - African American newspapers have been tested and shown to be effective in broadening the reach of cancer messages.
 - Asian Americans reported a significantly stronger preference for print materials.
 - Hispanic use of media for health information differed from other ethnic minorities and varied by acculturation.

Slide 7: Overview

- Discuss the role of evidential preferences in health decisions.
- Discuss the role and importance of personal experience in health decisions.
- Discuss the potential for counter-intuitive responses to health information.
- Discuss where we go from here.

Slide 8: Information and Decision Making

- What factors affect how we use health information?
 - Dervin (2005) notes that situational circumstances affect the sensemaking needs of information seekers.
 - Sense making refers to the strategies used to decide when, what, and how to use health information.
 - At various times there may be the need or desire for:
 - Facts or information from authorities
 - Information provided by peers or supportive others

Slide 9: Evidence and Responses to Health Information (1 of 2)

- Evidential approaches present the evidence of the effects of the disease on a given group.
 - Evidential statements seek to raise awareness, concern, and/or perceived personal vulnerability to a health concern by showing that it affects others similarly to members of the target audience.
 - o They may also affect acceptance and willingness to act on information.

Slide 10: Evidence and Responses to Health Information (2 of 2)

- Lipkus et al. (1999) confirmed the importance of presenting risks.
 - Presenting risk information increased perceived risk without increasing worry, fear, or anxiety.
 - o How should risk information be presented?

- Royak-Schaler et al. (2004) found a preference for information about family history and personal risk.
 - Arkes and Gaissmaier (2012) have a preference for information in graphic and quantitative forms.

Slide 11: Evidential Preferences (1 of 5)

- A goal of the Washington University National Cancer Institute- funded Center for Excellence in Cancer Communication Research (CECCR) in St. Louis was to increase the reach and relevance of cancer communication.
 - One strategy for reaching the CECCR goal was to increase understanding of community reaction to the presentation of cancer statistics.
 - Nine focus groups:
 - 3 females (n = 17)
 - 6 males (n = 32)
 - Groups were presented with cancer- related evidential statements.
 - Statements that provide or discuss data specific to that group.

Slide 12: Evidential Preferences (2 of 5)

- General statistical data
- Ethnic-specific statistics
- Statistics highlighting disparities
- Social math examples (creative epidemiology)
- Positive and negative framing: survival and mortality data

Slide 13: Evidential Preferences (3 of 5)

- General Statistical Data
 - o Participants related their experiences or behaviors to the statement.
 - Participants desired more information (signs, symptoms, and steps for change).
 - o Participants dismissed data using estimates or approximations.
- Ethnic-Specific Statistics
 - Helped participants see themselves as a part of a high-risk group.
 - Mistrust surfaced during the discussions, with participants questioning sources, statistics, and the motives of organizations providing data.
 - Consistent with past research that notes the appeal of health information that depicts members of the targeted group (Resnicow et al., 1999; Kreuter et al., 2003).

Slide 14: Evidential Preferences (4 of 5)

- Health Disparity Data
 - Evoked negative emotions and feelings of mistrust
 - Stimulated a discussion of:
 - Motives of organizations compiling data
 - Desire to have information on rates for similar ethnic groups
- Social Math
 - o The data seemed more personal.
 - o Female participants found the statements referencing family relevant.
 - Male participants who preferred social math indicated a preference for data using family or a sports reference.

Slide 15: Evidential Preference (5 of 5)

- Positive and Negative Framing
 - Participants had difficulty understanding 5-year probability of survival: "Ninety percent of the people diagnosed in the early stages of colorectal cancer survive at least five years."
 - When participants had a preference, positive framing (survival data) was selected because of its association with a sense of hope.
 - o Mortality statistics provoked fear and thoughts of death.
 - If disease and death were viewed as inevitable, participants speculated that there would be no reason for action.
 - Participants requested statistics that were easier to understand actual numbers and ratios.

Slide 16: Comparative Health Communications

- A study of racially comparative cancer information indicated that participants exposed to disparity articles reported less intention to be screened for colorectal cancer.
- In contrast, progress articles elicited greater intention to be screened (Nicholson et al., 2008).
- These effects are more intense for individuals with high mistrust.

Slide 17: Nonstatistical Evidence and Health Decisions (1 of 2)

- Testimonials and statements related to personal, family or group experience can also be used as a form of evidence.
 - Testimonials are usually compelling and easy to understand on an emotional as well as a cognitive level.
- Anecdotes influence responses to health behavior guidelines and treatment choice.

Slide 18: Nonstatistical Evidence and Health Decisions (2 of 2)

- Studies have shown that anecdotes are more powerful than a variety of statistical presentations of data.
 - Anecdotes can influence a person's belief about how behavior, disease, and treatment affects him or her through the experience of similar others.
 - Fagerlin et al. (2005) illustrated the power of anecdote on treatment choice.
 - They provided statistics to two groups but varied the representativeness of the anecdotes presented.
 - Anecdotes allow people to identify the recipients of treatment and those experiencing disease to be known.
 - They enhance concern (Slovic, 2007).

Slide 19: Personal Experience and Health Decisions

- Individuals reflect on their experience in terms of harm or benefit.
 - Information that would allow appropriate comparisons is not readily available.
- Participants were more likely to report trust when evidential statements were consistent with their personal experience.
 - o They verbalized doubt when the two were inconsistent.
- It is difficult to avoid this bias, both affective and cognitive, in real life.

Slide 20: What Do We Do When We Don't Know What To Do?

- In addition to the psychic numbing in the face of statistical data, there are other counterintuitive responses to information or the lack of it.
- Shepherd and Kay (2012) noted a counterintuitive response to lack of information and knowledge about sociopolitical issues that might be applicable to health.
 - o Particularly if they are important, relevant, and immediate
 - o Expectation seek knowledge and engage
 - o Observe some avoid new information, place trust in authority

Slide 21: Evidence in the Clinical Setting

- Provide data on harms as well as benefits.
- Prepare health professionals to listen to and discuss patient experiences.
- Pair statistics with messages that provide strategies for action.
 - This information may increase the perception that materials are useful.
- Include positive health trends when relevant and feasible.
 - o This strategy may encourage hopeful attitudes.

Slide 22: Communicating Evidence

- The Issue is translating between population-level data and personal risk.
 - o Include social math strategies.
 - o Graphically show risks/harms, as well as benefits (facts boxes).
 - o Integrate a variety of evidence-based health information platforms.
 - o Engage in discussions about the health information gathered.

Slide 23: Research Needs

- How do we train physicians to engage in conversations that provide evidence-based data in a health literate manner that promotes informationbased decision making?
 - o Provide verbal instructions that are easily understood.
- How do we successfully integrate technology-based health information platforms into physician offices?
- What is the right balance of consumer-targeted health information and physician/patient discussion in the health care setting.